

Sleep Questionnaire Today's date: ___/___/___ MR# _____

Patient name: _____ Age: _____ DOB: ___/___/___

Marital status: _____ Gender: M F Height: ___ft___in Weight: _____ lbs

Ethnicity: _____ Referred by: _____

 Reason for the visit: Insomnia Sleep apnea Other: _____

 Have you been previously evaluated for a sleep disorder? No Yes

 Have you ever had an overnight sleep study? No Yes

I. EPWORTH

 How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

Never	Slight	Moderate	High	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sitting and reading
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Watching TV
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sitting inactive in a public place (example: a theater or meeting)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	As a passenger in a car for 1 hour without a break
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lying down to rest in the afternoon when circumstances permit
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sitting and talking to someone
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sitting quietly after lunch without alcohol
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	In a car (driving) while stopped for a few minutes in traffic

II. Questionnaire:

 Do you snore? No Yes Don't know

 Your snoring is: Slightly louder than breathing As loud as talking Louder than talking Very loud

 Has your snoring ever bothered other people? No Yes

 Do you have high blood pressure, or take medication for high blood pressure? No Yes

<i>Please check the appropriate box :</i>	Nearly every day	3-4 times a week	1-2 times a week	1-2 times a month	Never or nearly never
How often do you snore?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Has anyone noticed that you quit breathing during your sleep?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
During your wake time, do you feel tired, fatigued or not up to par?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Have you ever nodded off or fallen asleep while driving a vehicle? <input type="checkbox"/> No <input type="checkbox"/> Yes <u>If yes</u> , how often does it occur?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Do you have headaches after waking up?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Do you have a dry mouth at night?	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

III. Sleep Habits – Please answer questions based on an average night of sleep:

Bedtime _____ AM/PM Time to fall asleep _____ min Wake time _____ AM/PM Out of bed time _____ AM/PM Approximate sleep duration _____ hours
Weekdays: _____ AM/PM _____ min _____ AM/PM _____ AM/PM _____ hours
Weekends: _____ AM/PM _____ min _____ AM/PM _____ AM/PM _____ hours

Do you consider yourself a night owl? No Yes

Do you consider yourself a morning person? No Yes

Do you take medication or a supplement to help you sleep? No Yes: _____ Dose: _____

Do you need an alarm clock to wake up in the morning? No Yes

How many naps do you take per week? _____ What is the average duration of each nap? _____

Are these naps refreshing? No Yes Do you dream during naps? No Yes

<i>Check the answer that best describes how often you experience each situation:</i>	<i>Never</i>	<i>Less than 2 times a week</i>	<i>2-4 times a week</i>	<i>At least 5 times a week</i>
Taking sleeping pills to help you sleep	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Having trouble falling asleep	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Having very restless sleep	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Waking up several times at night	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Having trouble getting back to sleep	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Waking up earlier than you wanted to	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Waking up in the morning unrefreshed	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Feeling sleepy despite adequate sleep	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Feeling fatigued despite adequate sleep	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

Do you have unusual behaviors during sleep? No Yes

If yes: Nightmares Sleepwalking Bedwetting Other: _____

Do you grind or clench your teeth at night? No Yes If yes, do you use a dental guard? No Yes

Have you ever been told by others that you act out your dreams? No Yes

Have you ever felt paralyzed when you first wake up or when you are falling asleep? No Yes

Have you ever experienced episodes of muscle weakness, loss of muscle strength or limp muscles in any part of your body during the following situations:

When you laugh No Yes

When you are angry No Yes

When hearing or telling a joke No Yes

When tense or under stress No Yes

Have you ever had the sensation of seeing or hearing things when waking up or falling asleep? No Yes

IV. RLS - Please check the appropriate box:

- Do you kick your legs at night, prior to or during sleep? No Yes
- Do you ever experience a desire to move your legs due to discomfort or disagreeable sensations in your legs? No Yes
- Do you sometimes feel the need to move to relieve the discomfort, for example by walking or rubbing your legs? No Yes
- Are these symptoms worse later in the day or at night? Not applicable No Yes
- Are these symptoms worse when you are at rest, with at least temporary relief by activity? Not applicable No Yes
-

V. CPAP (for CPAP users only - skip this section if you do not use CPAP):

How many nights per week do you use your CPAP? _____ nights/week

How many hours per night do you use your CPAP? _____ hours/night

While using CPAP, are any of the following problems present?

- | | | |
|---|---|--|
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Dry mouth/dry nose | <input type="checkbox"/> Mask marking the face |
| <input type="checkbox"/> Gasping or choking | <input type="checkbox"/> Stuffy or running nose | <input type="checkbox"/> Bridge of nose discomfort |
| <input type="checkbox"/> Witnessed apnea | <input type="checkbox"/> Ear pain/ear popping | <input type="checkbox"/> Skin sore or acne from mask |
| <input type="checkbox"/> Unrefreshing sleep | <input type="checkbox"/> Irritated, dry or red eyes | <input type="checkbox"/> Machine noise |
-

VI. SOCIAL HABITS: Profession/Job: _____

Occupational Status: Actively working Retired Disabled Shift worker

Are you sedentary (no more than 10 minutes of uninterrupted physical activity) during the day? No Yes

Do you exercise for more than 30 minutes at least two times a week? No Yes

Do you smoke or have you ever smoked? No Yes

If so, how many cigarettes a day? _____ For how long? _____

If you quit smoking, how long ago did you quit? _____

How many cups of coffee do you drink each day? _____

How many ounces of other caffeinated beverage (e.g. soda, tea, energy drinks) do you drink a day? _____

Do you think you are sensitive to caffeine? No Yes

Do you drink alcoholic beverages? No Yes Types of drinks: _____ Amount: _____ per week/day

Do you use any recreational drugs? No Yes Decline to answer

VII. Family History - Please check the box if you have more than 1 family members with the following:

- Sleep Apnea Restless Legs Night type Morning type Narcolepsy
-

VIII. Medications - Please check the box if you take any of the following medications on a regular basis:

- | | | |
|--|--|----------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Blood pressure pills | <input type="checkbox"/> Insulin |
| <input type="checkbox"/> Cholesterol pills | <input type="checkbox"/> Sedatives | <input type="checkbox"/> Oxygen |
| <input type="checkbox"/> Blood thinners | <input type="checkbox"/> Tylenol, Advil, painkillers | |
| <input type="checkbox"/> Sleep medications (name): _____ | | |

Other medications and dosage: _____

Please list any allergies: _____ none known

Please list any major surgeries you have had: _____
